Report

of the

Examination of

Atrium Health Plan, Inc.

Hudson, Wisconsin

As of December 31, 2002

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor Jorge Gomez, Commissioner

Wisconsin.gov

June 26, 2003

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Honorable Jorge Gomez Commissioner of Insurance Madison, Wisconsin

Commissioner:

In accordance with your instructions, a compliance examination has been made of the affairs and financial condition of:

ATRIUM HEALTH PLAN, INC. Hudson, Wisconsin

and this report is respectfully submitted.

I. INTRODUCTION

The previous examination of Atrium Health Plan, Inc. (Atrium or the company), was conducted in 1999 as of December 31,1998. The current examination covered the intervening period ending December 31, 2002, and included a review of such 2003 transactions as deemed necessary to complete the examination.

The examination consisted of a review of all major phases of the HMO's operations, and included the following areas:

History
Management and Control
Corporate Records
Conflict of Interest
Fidelity Bonds and Other Insurance
Provider Contracts
Territory and Plan of Operations
Affiliated Companies
Growth of the HMO
Reinsurance
Financial Statements
Accounts and Records
Data Processing

Emphasis was placed on the audit of those areas of the company's operations accorded a high priority by the examiner-in-charge when planning the examination. Special attention was given to the action taken by the company to satisfy the recommendations and comments made in the previous examination report.

The section of this report titled "Summary of Examination Results" contains comments and elaboration on those areas where adverse findings were noted or where unusual situations existed. Comments on the remaining areas of the company's operations is contained in the examination work papers.

The company is annually audited by an independent public accounting firm as prescribed by s. Ins 50.05, Wis. Adm. Code. An integral part of this compliance examination was the review of the independent accountant's work papers. Based on the results of the review of these work papers, alternative or additional examination steps deemed necessary for the completion of this examination were performed. The examination work papers contain documentation with respect to the alternative or additional examination steps performed during the course of the examination.

II. HISTORY AND PLAN OF OPERATION

Atrium Health Plan, Inc., is a nonprofit, network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "a health care plan offered by an organization established under ch. 185, 611, 613, or 614, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the network model, the company provides care through contracts with two or more clinics. HMOs compete with traditional fee-for-service health care delivery.

The company was incorporated August 17, 1984, as HMO Midwest and commenced business on that day. The company is organized under ch. 613, Wis. Stat., as a nonstock service insurance corporation. Atrium is controlled by Blue Cross Blue Shield of Minnesota (BCBSM), a nonprofit health service organization domiciled in Minnesota.

The company provides primary and specialty care through a large network of primary care physicians, clinics, specialists, and hospitals that contract with the company or one of its affiliates. BCBSM and Blue Plus, a Minnesota HMO controlled by BCBSM, have large provider networks in Minnesota and in bordering counties in adjacent states. The networks are available to Atrium enrollees pursuant to a provision in BCBSM and Blue Plus provider agreements allowing Atrium the same negotiated rates. Generally, the company contracts directly with providers who are located in Wisconsin counties. HMO enrollees are required to choose a primary care physician, who must preauthorize all referrals. Beginning in October 2000, Atrium began offering an open access PPO Product.

Atrium has subcontracted with another HMO insurer, Group Health Cooperative of Eau Claire (GHC), to provide Medicaid contract services to recipients enrolled in Atrium under the State Medicaid Plan. For each member month, GHC receives the Medicaid capitation rate less a negotiated deduction. In addition, GHC shall reimburse Atrium for the net cost of providing required credentialing of providers for this Medicaid HMO program. GHC is authorized to receive capitation payment directly from the Wisconsin Department of Health and Family Services

(DHFS), and must then pay Atrium its share within 5 days' of receipt of the payment from DHFS. In the event of a DHFS increase in Medicaid HMO capitation rate, the amount of GHC's share of the capitation payment under this agreement is increased by the exact amount of the increase that is earmarked for medical services by DHFS. (Increases for nonmedical services are not passed on to GHC.) Enrollees are to be held harmless for payment of monies for covered services. The agreement became effective July 1, 1996, and had an initial term of 5½ years. The contract has been extended for another two year term, expiring on December 31, 2003. Either party may terminate with two years notice prior to the end of the original or any renewal term. The agreement shall also terminate if Atrium's contract with DHFS is terminated.

Primary care providers contracting with the company or its affiliates agree to provide medical and hospital services, and to provide or arrange for 24-hour emergency services. Physicians receive the lesser of billed charges or an amount determined by a fee schedule as reimbursement for their services. If the company is unable to meet its financial obligations, the providers agree to hold enrollees harmless from all liability related to services provided.

Either party may terminate the agreement without cause on the last day of any calendar month by giving 130 days advance written notice. The company may terminate at any time if the provider does not meet utilization, quality of care, enrollment, or other standards, or if the provider has breached the agreement. Termination does not relieve the company or provider from providing services to any enrollee confined in a hospital or other inpatient facility until discharged or 12 months from termination, whichever comes first.

Referral providers receive as reimbursement 80% to 90% of the lesser of billed charges or the maximum amount permitted by the company's fee schedule. Providers of mental health/chemical dependency services are paid on a variety of payment methods including reduced fee schedules.

The company contracts with the following Wisconsin hospitals:

Hospital	Citv

Amery Regional Medical Center Amery
Baldwin Community Memorial Hospital Black River Memorial Hospital Black River Falls

Black River Memorial Hospital Black River
Burnett Medical Center Grantsburg
Chippewa Valley Hospital Durand
Grant Regional Health Center Lancaster
Hayward Area Memorial Hospital Hayward

Hayward Area Memorial Hospital
Holy Family Hospital
New Richmond
Hudson Medical Center
Indianhead Medical Center
Lakeview Medical Center
Lutheran Hospital
Hayward
New Richmond
Hudson
Shell Lake
Lake
Lake
La Crosse

Memorial Medical Center Ashland
Osceola Medical Center Osceola

Desiried Object Medical Center Osceola

Prairie du Chien Memorial Hospital Prairie du Chien River Falls Area Hospital, Inc. River Falls
Sacred Heart Hospital Eau Claire
Spooner Community Memorial Hospital Spooner

Spooner Community Memorial Hospital
St. Croix Valley Memorial Hospital
St. Joseph's Hospital
St. Mary's Hospital
Spooner
St. Croix Falls
Chippewa Falls
Superior

St. Joseph's Hospital
St. Mary's Hospital
Superior
Tomah Memorial Hospital
Tri County Memorial Hospital
Whitehall

Enrollees also have access to hospitals in Minnesota through BCBSM's provider

network. Hospitals are reimbursed on a negotiated DRG or discounted fee-for-service basis.

The contracts include hold-harmless provisions for the protection of the policyholders.

The company is authorized to do business in the following counties:

Ashland Grant Richland Barron Iron Rusk Bavfield Sawver Jackson Buffalo St. Croix Juneau Trempealeau Burnett La Crosse Chippewa Monroe Vernon Crawford Pepin Vilas Douglas Pierce Washburn

Dunn Polk
Eau Claire Price

The company offers comprehensive health care coverage which may be changed by riders to include deductibles and copayments. The following basic health care coverages are provided:

Physician services Inpatient hospital services Outpatient services Mental health, chemical dependency Ambulance services Dental care Emergency care Prosthetic devices and durable medical equipment Prenatal care and child delivery Home health care (up to 40 visits per year) Home infusion therapy Preventive health services Family planning Diabetes treatment Routine eye examinations Prescription drugs—with copayment Skilled nursing facilities Cardiac rehabilitation, physical, speech, and/or occupational therapy Reconstructive surgery Certain organ and bone marrow transplants Chiropractic services

In accordance with the company's primary health care plan, mental health and chemical dependency coverage is limited as follows: inpatient--30 days and \$6,300, outpatient--\$1,800 per year, transitional treatment--\$2,700 per year. Emergency services have copayments that vary by plan and are waived upon admission into an inpatient facility. Plan coverage is contingent on nonemergency services being provided by participating physicians and hospitals or on the referral of participating physicians. The company also has a copayment plan in which most services have a 20% copay subject to annual out-of-pocket maximums, which vary depending upon the plan chosen. Members are required to choose a primary care physician from the listing of available participating physicians.

The company, in cooperation with MII Life, Inc. (MII), an affiliated company, offers a jointly marketed product, effectively creating a point-of-service product. Enrollees who belong to groups that choose this option may receive health care from HMO providers at substantially the same benefit levels as other HMO enrollees, or from outside providers at reduced benefit levels. Groups choosing this product are under contract with both the company and MII. The company is

at risk only for claims submitted by HMO providers for approved services, including emergency room services, physician services and inpatient hospital care. MII is at risk for all other claims. Premiums are divided between the company and MII.

The company also participates as a third-party administrator for a self-insured product. The employer group elects to self-insure its enrollees for all claims up to a stop-loss limit. Claims in excess of the stop-loss limit are the responsibility of MII, under stop-loss contracts executed between MII and the group. Under a servicing agreement, the company receives reimbursement for all claims paid, plus an administrative service charge. The volume of administrative services contracts (ASC) business was fairly consistent in 1999 and 2000. In 2001, Atrium added the School District of Superior, a substantially large group that led to the increase in ASC business since the previous examination. The operating results on the ASC business appear to have improved. The following data compares ASC volume in 1999 and 2002, and related operating results:

ASC Business

	1999	2002
Revenue Expenses:	\$2,313,138	\$7,132,500
Medical Administration	2,066,910 181,265	6,654,929 170,998
Net Income	\$ 64,963	\$ 306,573

Regarding its insured business, the company determines premium rates for each group by using the group's past claims experience. Groups of less than 50 enrollees are also rated based on experience, but are subject to maximum rate changes. Total claims from the previous year are adjusted for inflation to obtain the projected claims for the renewal year. To this projection, a factor is added for administrative costs. The company reviews the result and determines what rate is required. The rate may be adjusted to reflect the age, sex, and coverage characteristics of the group. For new groups of 50+, the company attempts to obtain claims experience from the group's previous carrier for purposes of rate determination. If the claims

experience cannot be obtained, the company uses an actuarially determined rate based on the group's age, sex, and other characteristics, including health history.

The company currently markets to groups and individuals. The plan uses its own marketing staff and outside brokers. Commissions paid to brokers for individual policies are 15% for new business and 10% for renewals. Commissions paid on groups over 50 employees are determined on a graded scale based on premium volume. Commissions paid on small groups (2-49) are a flat amount per member, depending on the size of the group.

III. MANAGEMENT AND CONTROL

Board of Directors

The board of directors consists of six members, who are elected annually by BCBSM.

Officers are elected by the board of directors. Members of the company's board of directors may also be members of other boards of directors in the BCBSM group. Board members are compensated as follows:

Annual retainer for the chairman	\$5,000
Annual retainer for outside board members	2,500
Per diem for each board meeting attended	500

Currently the board of directors consists of the following persons:

Name	Principal Occupation	Residence
George Emslie, Chair	Retired	Eagan, MN
Leonard Franklin, Vice Chair	President, L&F Enterprises	St. Paul Park, MN
Colleen Reitan	Senior Vice President Blue Cross Blue Shield Minnesota	St. Paul, MN
Thomas Wishman	Staff Representative AFFCME, Council 40, AFLCO	Mt. Calvary, WI
Lawrence Weisenbeck	Retired	New Richmond, WI
Les Martisko, Ph.D.	Executive Director, South Central Service Cooperative	Lakeville, MN

Officers of the Company

The officers elected by the board of directors and serving at the time of this examination are as follows:

Name	Office	2002 Salary
Gregg Larson	President and CEO	87,511*
Robert Milis	Secretary	2,070*
Timothy Schultz	Treasurer	1,745*
Marsha Shotley	Assistant Secretary	925*

^{*}Compensated by BCBSM. Figure represents the portion of salary allocated to Atrium.

The company has no employees. Necessary staff is provided through an administrative services agreement with BCBSM. Under the agreement, effective

October 9, 2000, BCBSM agrees to provide virtually all management and administrative functions including negotiating provider, subscriber and other contracts; advising the board; maintaining accounting and financial records; recruiting, marketing, utilization review, and claims processing personnel; providing or contracting for claims processing; and MIS. Payment for services is based on the actual expenses and costs of the services as allocated using cost accounting procedures.

BCBSM agrees to make necessary contributions to the company to maintain the company's net worth at the required statutory level. The company must issue a contribution note or another agreement between the parties in order to obtain such contributory funds.

According to the terms of the administrative services agreement, in the event of insolvency or dissolution of the company:

BCBSM agrees to make any additional contributions to the HMO which are necessary to allow the HMO to fund any contractual or other financial obligations the HMO has entered into, including, but not limited to any contractual obligation to provide coverage to enrollees under the terms and conditions of the enrollees contract with the HMO. Provided, however, at no time shall BCBSM be obligated to advance funds or make additional contributions to Atrium if BCBSM does not meet its statutory reserve requirements under Minnesota Statutes Chapter 62C.

The agreement is perpetual, but may be terminated by either party giving 12 months advance written notice.

Financial Requirements

The financial requirements for an HMO under s. Ins 9.04, Wis. Adm. Code, are as follows:

Amount Required

1. Minimum capital or permanent surplus

Either:

\$750,000, if organized on or after July 1, 1989

or

\$200,000, if organized prior to July 1, 1989

2. Compulsory surplus

The greater of \$750,000 or:

If the percentage of covered liabilities to total liabilities is less than 90%, 6% of the premium earned in the previous

12 months;

If the percentage of covered liabilities to total liabilities is at

least 90%, 3% of the premium earned in the previous 12

months

3. Security surplus

The greater of:

140% of compulsory surplus reduced by 1% of compulsory

surplus for each \$33 million of additional premiums earned

in excess of \$10 million

or

110% of compulsory surplus

4. Operating funds

Funds sufficient to finance any operating deficits in the business

and to prevent impairment of the insurer's initial capital or

permanent surplus or its compulsory surplus

Covered liabilities are those due to providers who are subject to statutory hold-harmless

provisions.

In addition, there is a special deposit requirement equal to the lesser of the following:

- 1. An amount necessary to maintain a deposit equaling 1% of premium written in this state in the preceding calendar year;
- 2. One-third of 1% of premium written in this state in the preceding calendar year.

The company has satisfied this requirement for 2002 with a deposit of \$400,000 with the State

Treasurer.

Insolvency Protection for Policyholders

Under s. Ins 9.04 (6), Wis. Adm. Code, HMOs are required to provide continuation of coverage for its enrollees. These requirements are the following:

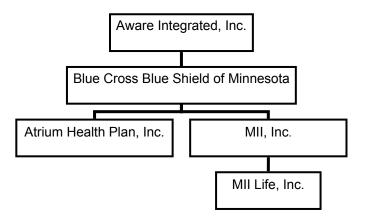
- 1. Enrollees hospitalized on the date of insolvency will be covered until discharged; and
- 2. Enrollees will be entitled to similar, alternate coverage which does not contain any medical underwriting or preexisting limitation requirements.

The company has met this requirement through its reinsurance contract, as discussed in the Reinsurance section of this report.

IV. AFFILIATED COMPANIES

The company is a member of a holding company system. Its ultimate parent is Aware Integrated, Inc (Aware). The organizational chart below depicts the relationships among the affiliates in the group. A brief description of the significant affiliates of the company follows the organizational chart.

Holding Company Chart As of December 31, 2002



Aware Integrated, Inc. (Aware)

Aware Integrated, Inc. (Aware), a Minnesota nonprofit holding company, is the sole member of BCBSM. It elects all the trustees of BCBSM, and ultimately, elects all the company's directors. Through its subsidiaries, Aware provides health and life insurance products and administrative services to self-insured employers and other organizations. The company also provides information system services, pharmacy benefit management services, and other ancillary services to health plans located through the United States.

As of December 31, 2002, Aware's audited consolidated financial statements reported assets of \$1.80 billion, liabilities of \$1.02 billion, a minority interest in net assets of subsidiaries of \$11 million and total equity of \$773 million. Operations for 2002 produced net income of \$39 million on revenues of \$2.5 billion.

Blue Cross and Blue Shield of Minnesota

BCBSM, a Minnesota nonprofit health service plan corporation, is the sole member of Atrium Health Plan, Inc. BCBSM selects the company's board of directors and has all other rights authorized for members by ch. 613, Wis. Stat. Substantially, all general and administrative services necessary to the company's operations are provided by BCBSM under the terms of a management agreement as described in the section of this report captioned "Management and Control." Some of the company's providers, particularly hospitals, are actually under contract with BCBSM. The contracts provide that all affiliates of BCBSM are allowed the same negotiated rates.

As of December 31, 2002, BCBSM's audited financial statements reported assets of \$1.32 billion, liabilities of \$826 million and statutory reserves of \$495 million. Operations for 2002 produced a net income of \$48 million on premiums of \$1.5 billion. In 1998, BCBSM settled its claims for past and future damages against the tobacco industry for a payment of \$469 million, subject to certain adjustments. In June 2002, the Minnesota Commissioner of Commerce issued an order approving BCBSM's plan of action to correct its excess surplus condition which resulted from the tobacco settlement and authorizing expenditure of tobacco funds. The plan entitles \$60 million in rebates to members, a \$70 million payment to Minnesota Comprehensive Health Association, a \$30 million payment to community clinics, and the remaining funds, having a present value as of December 31, 2001 of \$252 million, will be used over the next ten years to reduce tobacco use, improve cardiovascular health and prevent cancer. The ultimate use of tobacco proceeds cannot be assured until all legal actions regarding the proceeds have been finally settled and final regulatory approval is obtained. BCBSM's financial statements amounts related to the tobacco proceeds are presented in accordance with the Plan of Action.

MII Life, Inc. (MII)

MII is a Minnesota domiciled insurer which writes primarily group life and accident and health insurance. MII is licensed in Wisconsin and is 100% owned by BCBSM. As indicated in the section of this report captioned "History and Operations," MII is at risk for claims submitted by non-HMO providers under a point-of-service option plan, and for claims in excess of stop-loss

limits under the self-insured option plan. There is currently no administrative agreement in place to describe this relationship as discussed in the section of this report captioned "Summary of Examination Results."

As of December 31, 2002, MII's filed audited financial statement reported assets of \$63.6 million, liabilities of \$26.9 million and surplus of \$36.7 million. Operations for 2002 produced net income of \$1.7 million on revenues of \$26 million

V. REINSURANCE AND CORPORATE INSURANCE

The company has reinsurance coverage under the contract outlined below:

Reinsurer: Blue Cross Blue Shield of Minnesota

Type: Excess of Loss

Effective date: January 1, 1992

Retention: \$50,000

Coverage: 90% of expenses in excess of retention

Premium: \$6.63 per member per month

Termination: By either party giving 90 days' advance written notice

The reinsurance policy does not have an insolvency provision as required by s. Ins 9.04(6), Wis. Adm. Code. However, the management agreement discussed previously in this report noted that the parent, BCBSM, will make any additional contributions to the company which are necessary in the event of insolvency or bankruptcy provided that BCBSM is not required to make contributions if BCBSM does not meet its statutory reserve requirements. This provision in the management agreement appears to adequately satisfy the necessary guarantees regarding insolvency protection for the policyholders.

In addition, the company is provided with corporate insurance coverage under the contracts listed below:

Type of Coverage	Policy Limits
Fidelity Bond	\$10,000,000
Directors and Officers	40,000,000
Errors and Omissions	40,000,000
Managed Care Organization Liability	40,000,000
Employment Practices Liability Insurance	5,000,000
E-Commerce Liability and E-Commerce Business	
Losses Insurance	5,000,000
Employers Managed Care Liability	5,000,000
Umbrella	19,000,000
Fiduciary Liability	5,000,000

The above coverages were obtained through insurers that are licensed in Wisconsin.

VI. FINANCIAL DATA

The following financial statements reflect the financial condition of the company as reported in the December 31, 2002, annual statement to the Commissioner of Insurance. Also included in this section are schedules that reflect the growth of the company for the period under examination. Adjustments made as a result of the examination are noted at the end of this section in the area captioned "Reconciliation of Net Worth per Examination."

Atrium Health Plan, Inc. Assets As of December 31, 2002

	Assets	Nonadmitted Assets	Net Admitted Assets		
Bonds Cash and short-term investments Accident and health premiums due and unpaid Health care receivables Investment income due and accrued Amounts receivable relating to uninsured accident and health plans Aggregate write-ins for other than invested assets Total assets	\$12,944,662 12,179 497,188 343,166 106,442 124,099 72,646 \$14,100,382	\$337,483 \$337,483	\$12,944,662 12,179 497,188 5,683 106,442 124,099 72,646 \$13,762,899		
Atrium Health Plan, Inc. Liabilities and Net Worth As of December 31, 2002					
Claims unpaid Unpaid claims adjustment expenses Premiums received in advance General expenses due or accrued Amounts withheld or retained for the account of a Amounts due to parent, subsidiaries and affiliate Aggregate write-ins for other liabilities (including Total liabilities Unassigned funds (surplus) Total capital and surplus Total liabilities, capital and surplus	S	<u>\$7,101,707</u>	\$ 4,524,593 231,594 1,263,232 8,227 4,692 607,551 21,303 6,661,192 7,101,707 \$13,762,899		

Atrium Health Plan, Inc. Statement of Revenue and Expenses For the Year 2002

Net premium income Medical and Hospital:		\$76,876,503		
Hospital/medical benefits	\$68,793,178			
Other professional services	4,433,502			
Outside referrals	73,891			
Emergency room and out-of-area	<u>591,134</u>			
Subtotal	73,891,705			
Less				
Net reinsurance recoveries	2,380,468			
Total medical and hospital	71,511,237			
Claims adjustment expenses	1,349,645			
General administrative expenses	<u>2,963,425</u>			
Total underwriting deductions		75,824,307		
Net underwriting gain or (loss)		1,052,196		
Net investment income earned		628,359		
Aggregate write-ins for other income or expenses		68		
Net income (loss)		<u>\$ 1,680,623</u>		
Atrium Health Plan, Inc.				

Atrium Health Plan, Inc. Capital and Surplus Account As of December 31, 2002

Capital and surplus prior reporting year		\$5,758,567
Net income or (loss)	\$1,680,623	
Change in nonadmitted assets	(337,483)	
Net change in capital and surplus		1,343,140
Capital and surplus end of reporting year		\$7,101,707

Atrium Health Plan, Inc. Statement of Cash Flows (Direct Method) As of December 31, 2002

	Cash	1 fro	m	Ope	rati	ons	
1	rovo	nuo	0	ممالم	hot	not a	

Premiums and revenues collected net of reinsurance Claims and claims adjustment expenses General administrative expenses paid Cash from underwriting Net investment income Other income (expenses)		\$76,974,465 71,726,526 2,961,470 2,286,469 628,926 68
Net cash from operations Cash from Investments		2,915,463
Proceeds from investments sold, matured or repaid:		
Bonds	\$16,184,717	
Cost of investments acquired (long-term only): Bonds	19,927,610	
Net cash from investments		(3,742,893)
Cash from Financing and Miscellaneous Sources		
Cash provided:		
Net transfers from affiliates	1,508,111	
Other cash provided	<u>388,241</u>	
Total	1,896,352	
Cash applied:		
Other applications	<u>339,865</u>	4 550 407
Net cash from financing and miscellaneous sources		<u>1,556,487</u>
Net change in cash and short-term investments		729,057
Cash and short-term investments:		(716 970)
Beginning of year		(716,878) \$ 12,170
End of year		<u>\$ 12,179</u>

Growth of Atrium Health Plan, Inc.

				Medical		
Year	Assets	Liabilities	Capital and Surplus	Premium Earned	Expenses Incurred	Net Income
2002	\$13,762,899	\$6,661,192	\$7,101,707	\$76,876,503	\$71,511,237	\$1,680,623
2001	10,421,244	4,662,677	5,758,567	55,632,669	51,085,965	1,789,493
2000	7,075,332	3,176,258	3,899,074	34,882,661	31,888,156	318,771
1999	7,017,881	3,437,518	3,580,363	25,567,789	22,763,703	499,718
1998	7,566,946	4,486,301	3,080,645	27,634,654	26,453,794	(970,479)

Year	Profit Margin	Medical Expense Ratio	Administrative Expense Ratio	Change in Enrollment
2002	2.17%	93.02%	5.56%	17.1%
2001	3.20	91.83	5.48	45.8
2000	0.91	91.42	8.69	45.4
1999	1.93	89.03	10.30	-5.3
1998	-3.46	95.73	9.24	-2.1

Enrollment and Utilization

Year	Commercial Enrollment	Medicaid Enrollment	Hospital Days/1,000	Average Length of Stay
2002	14,889	27,062	374.58	3.4
2001	11,860	23,966	330.17	3.3
2000	8,203	16,375	417.41	3.6
1999	8,153	8,749	478.27	3.5
1998	9,840	7,999	443.10	4.1

Per Member Per Month Information

	2002	2001	Percentage Change
Premiums:			J
Commercial	\$216.98	\$196.89	10.2%
Medicaid	129.39	118.87	8.9
Expenses:			
Hospital/medical benefits	142.70	127.88	11.6
Other professional services	9.20	6.79	35.5
Outside referrals	0.15	0.14	7.1
Emergency room and out-of-area	1.23	1.09	12.8
Less: Net reinsurance recoveries	4.94	2.84	73.9
Total medical and hospital	148.34	133.06	11.5
Claims adjustment expenses	2.80	2.52	11.1
General administrative expenses	6.15	5.46	12.6
Total underwriting deductions	\$157.29	\$141.04	11.5

The company reported double digit increases in enrollment and premiums earned for the last three years. The loss ratio and administrative ratio has stayed consistent over the three year period; however, they are slightly skewed by the company's method for reporting its capitation expense under the GHC agreement. Under this agreement a portion of the capitation expense to GHC is an administrative expense. The company is reporting all its capitation expenses under this agreement as medical expenses. This is discussed further in the section of this report captioned "Summary of Examination Results."

Reconciliation of Capital and Surplus per Examination

There were no reclassifications or adjustments to capital and surplus as a result of the examination.

VII. SUMMARY OF EXAMINATION RESULTS

Compliance with Prior Examination Report Recommendations

There were three specific comments and recommendations in the previous examination report. Comments and recommendations contained in the last examination report and actions taken by the company are as follows:

 Business Plan—It is recommended that the HMO establish a new business plan within 90 days of adoption of this report. The new plan should specify specific strategies that the HMO should pursue based on an analysis of the successes and failures of the current plan, changes occurring in the industry since the current plan was developed, and the HMO's strengths and weaknesses at this time.

Action—Compliance

- 2. <u>Invested Assets</u>—It is again recommended that the HMO amend its custodial agreements such that they contain provisions requiring:
 - a) that the custodian is obligated to indemnify the HMO for any loss of securities occasioned by the negligence or dishonesty of the custodian's officers or employees, or burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction; and
 - b) that in the event there is a loss of the securities for which the custodian is obligated to indemnify the HMO, the securities shall be promptly replaced or the value of the securities and the value of any loss of rights or privileges resulting from said loss of securities shall be promptly replaced.

Action—Compliance

3. <u>HIRSP Assessment</u>—It is recommended that the HMO refile the HIRSP assessment forms eliminating the unauthorized deductions for all applicable years, and that the HMO not include the deductions in future filings. It is further recommended that the HMO pay any additional assessment amounts as determined by HIRSP.

Action—Compliance

Summary of Current Examination Results

Executive Compensation

The examination review of the Report on Executive Compensation (Form 22-060) for 2002 noted that the company is not reporting all compensation as instructed. The amounts reported on the form excluded the 401(k) company match, accruals for pensions, and health care benefits. It is recommended that the company complete the Report on Executive Compensation (Form 22-060) in accordance with its instructions.

Financial Reporting

Examination review of the Exhibit of Capital Gains and Losses noted that Atrium did not report any gains or losses. In Schedule D part 4 and part 5, Atrium reports the difference between consideration and the book/adjusted carrying value as an adjustment. The difference between the sale price and the consideration at the time of sale is a capital gain/loss not an adjustment to the carrying value. NAIC Annual statement instructions require that gains/losses be included in Column 13 of Schedule D part 4 and Column 15 in Schedule D part 5. The instructions also require gains be included as part of the Statement of Revenues and Expenses on line 24 and the completion of the Exhibit of Capital Gains and Losses. It is recommended the company complete the annual statement exhibits and schedules regarding capital gains/losses in accordance with the NAIC Annual Statement Instructions for Health Insurers.

The company does not allocate a portion of the capitation expense for its Medicaid enrollment under the GHC agreement to administrative expenses. Since some of the capitation paid to the subcontractor, GHC, is used for administrative costs, this should be reported in administrative expenses. Reporting the amount of capitation entirely in medical expenses skews the company's administrative and loss ratios. It is recommended the company allocate a portion of the capitation expense to administrative expenses.

Premiums Receivable

Atrium nets amounts over 90 days on its aging report by the type of plan. For instance, at year-end, the Atrium Standard Plan had a total receivable balance over 90 days due of \$(1,492.60). This balance included a receivable of \$563.90 that was not nonadmitted since the

total of the Atrium Standard Plan over 90 day balance was negative. This practice does not follow the guidance established by SSAP No. 6, which states all receivables with balances over 90 days should be non-admitted on the balance sheet. Atrium has a policy of only writing off "over 90" receivables if there is a receivable balance for that plan. Atrium should be looking at the over 90 day balance of each individual receivable and making a determination if the amounts are uncollectible. In the instance where the balance is a de minimus balance, only the amount over 90 days should be nonadmitted according to INT 01-01. Due to the fact any amount that would be nonadmitted was immaterial, no adjustment to the annual statement was made. It is recommended the company comply with SSAP No. 6 and INT 01-01 and properly report premium receivables that are over 90 days old.

Agents

The examination compared the company's list of licensed agents to the licensed agents listed by OCI. Testing produced seventeen exceptions. Four of the exceptions were for licensed agents the company had incorrectly listed as terminated agents. The other thirteen exceptions were terminations that were filed electronically, but had not been officially approved. In a sample of these cases the termination was not approved because the company back dated the termination date more than 15 days. It is recommended the company set up a procedure to monitor that filed terminations are accepted and that the company discontinue back dating its agents' termination dates by more than fifteen days. (Note: Subsequent to fieldwork the company sent an appointment action letter dated July 16, 2003, that showed all but one of the agents in question were subsequently terminated with an action date of July 14, 2003).

Affiliated Agreements

The company, in cooperation with MII Life, Inc. (MII), offers a jointly marketed product, effectively creating a point-of-service product. Premiums are divided between the company and MII. Atrium collects the premium on behalf of MII and then allocates a portion of the premium. In addition, Atrium is also billing, on behalf of MII, amounts for AD&D and Life insurance coverage to those groups with Atrium coverage and MII coverage. An administrative agreement to document this arrangement was requested from the company. No agreement

could be provided to the examiners. However, the company stated that it is currently working on the preparation of such an agreement. It is recommended the company submit the administrative agreement to this office within 30 days of adoption of this report.

Reinsurance

Examination testing provided that the company was reporting its reinsurance recoverable amounts on paid claims as on offset to claims payable. The company should be reporting the reinsurance recoverables as an asset in accordance with the NAIC <u>Annual Statement Instructions for Health Insurers</u>. It is recommended the company correctly report any reinsurance recoveries on its balance sheet in accordance with the NAIC <u>Annual Statement Instructions for Health Insurers</u>.

Compulsory Surplus Requirement

As noted in the section of this report captioned "Financial Requirements," HMOs are required to maintain minimum compulsory surplus. The company's calculation as of December 31, 2002, is as follows:

Assets Less: Special deposit Liabilities	\$13,762,899 300,000 <u>6,661,192</u>	
Total		\$6,801,707
Net premium earned Compulsory factor	76,876,503 <u>3%</u>	
Compulsory surplus		2,306,295
Compulsory Excess		\$4,495,412

VIII. CONCLUSION

Atrium Health Plan, Inc.'s, annual statement as of December 31, 2002, reported assets of \$13.8 million, liabilities of \$6.7 million and surplus of \$7.1 million. Operations for 2002 produced net income of \$1.68 million on revenues of \$76.8 million.

The company does not have its own employees. All administrative services are provided by BCBSM. In addition, under this service agreement, in the event of insolvency or dissolution of the company, BCBSM agrees to make any additional contributions to the company that are necessary to allow the company to fund any contractual or other financial obligations the company has entered into. However, at no time is BCBSM obligated to advance funds or make additional contributions to Atrium if BCBSM does not meet its statutory reserve requirements.

The company complied with all of the prior examination recommendations. The current examination resulted in no reclassifications or adjustments to surplus. Seven recommendations were made regarding Executive Compensation, Financial Reporting, Premium Receivables, and Agent Licensing.

IX. SUMMARY OF COMMENTS AND RECOMMENDATIONS

- Page 25 <u>Executive Compensation</u>—It is recommended that the company complete
 the Report on Executive Compensation (Form 22-060) in accordance with its
 instructions.
- 2. Page 25 <u>Financial Reporting</u>—It is recommended the company complete the annual statement exhibits and schedules regarding capital gains/losses in accordance with the NAIC Annual Statement Instructions for Health Insurers.
- 3. Page 25 <u>Financial Reporting</u>—It is recommended the company allocate a portion of the capitation expense to administrative expenses.
- 4. Page 26 Premium Receivable—It is recommended the company comply with SSAP No. 6 and INT 01-01 and properly report premium receivables that are over 90 days old.
- 5. Page 26 Agents—It is recommended the company set up a procedure to monitor that filed terminations are accepted and that the company discontinue back dating its agents' termination dates by more than fifteen days.
- 6. Page 27 Affiliated Agreements—It is recommended the company submit the administrative agreement to this office within 30 days of adoption of this report.
- 7. Page 27 Reinsurance—It is recommended the company correctly report any reinsurance recoveries on its balance sheet in accordance with the NAIC Annual Statement Instructions for Health Insurers.

X. ACKNOWLEDGMENT

The courtesy and cooperation extended during the course of the examination by the officers and employees of the HMO is acknowledged.

In addition to the undersigned, the following representatives of the Office of the Commissioner of Insurance (OCI), State of Wisconsin, participated in the examination:

Name Title

Mark Knievel Insurance Financial Examiner

Randy Milquet Insurance Financial Examiner-Advanced

Respectfully submitted,

Danielle C. Rogacki Examiner-in-Charge